Neurology Associates Northwest
Consent to use or Disclose medical information

I authorize Christopher Ginocchio MD, Beenish K Khwaja DO, Elizabeth North DO & Kirk Weller MD (otherwise known as Neurology Associates Northwest) to use and disclose the health and medical Information of ____ for the purposes of treatment,
Patient Name

payment and healthcare operations*.

- Treatment (includes activities preformed by a physician, nurse, office staff and other types of healthcare professionals providing care to you, coordination of managing your care with third parties, and consultations with and between other healthcare providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on call physician.

- Payment includes activities involved in determining your eligibility for health plan coverage, bill and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justifications of charges, pre-certification and preauthorization.

- Health Care Operations includes the necessary administrative and business functions of our office. This includes any correspondence received in our office by way of mail, facsimile, phone or e-mail.

You may review Dr's Christopher Ginocchio, Beenish K Khwaja, Elizabeth North & Kirk Weller (otherwise known as Neurology Associates Northwest) "Notice of Privacy Practices" for addition information about the uses and disclosures of information described in this CONSENT prior to signing this CONSENT. Please verify that you have received a copy of our notice by placing your initials here: ______________________________

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the notice may change also. A summary of the notice will be posted in the lobby of our office indicating the effective date of the notice in the upper right hand corner. We will offer you a copy of the notice on your first visit to us after the effective date of the then current notice. We will also provide you with a copy of the notice upon your request.

As more fully explained in the notice, you have the right to request restrictions on how we use and disclose you protected health information for treatment, payment and health care operation purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consent with the notice.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that Dr's Christopher Ginocchio, Beenish K Khwaja, Elizabeth North and Kirk Weller (Otherwise known as Neurology Associates Northwest) have already used of disclosed the information in reliance on this consent.

____ ______________________________

Signature of Patient OR Signature of Person Authorized by Law Date